Wyoming Department of Health
Commit to your health.

APPLICATION FOR THE SEVERE MALOCCLUSION PROGRAM
Return Application AND REFERRAL to: 6101 Yellowstone Road, Suite 420, Cheyenne, WY 82002

1. Patient Information :

Name : _____ Male/Female Birth date:_____
Last Name, First Name, MI

Mailing Address:_____
Street Address or P.O. Box City County Zip Code

Physical Address:_____
(If not the same as mailing address) Street Address City County Zip Code

Social Security Number:_____ **Medicaid/Equality Care Number**:_____
(Optional)

Home Phone:_____ Work Phone:_____ Message Phone:_____

2. Parent/Guardian Information:

Name of Father / (Step) / Guardian:_____

Name of Mother / (Step) / Guardian:_____

Address if different from Patient:_____

Total Number of People Living In Household:_____(Complete Family Case Sheet, page 3)

3. Dentist/Orthodontist/PHN:

Name and Address of Dentist:
_____

Name and Address of Orthodontist:
_____

Name and County of PHN (Public Health Nurse) or School Nurse:
_____

The information you have provided will remain confidential with the Department of Health**, EXCEPT** in the following circumstances:

The Dental Health Program (DHP) as part of the Department of Health is a covered entity. DHP may request from any state agency, insurer, group health plan, health maintenance organization or similar entity any or all of your protected health information. This information includes the recipient's name, social security number, amount of payment, charge for services, date of services, and services rendered related to medical payment. This information may be used or disclosed for the process of treatment, payment or healthcare operations. This is in accordance with the Health Information Portability and Accountability Act section 164.502(a)(1)(ii). Please see your Client Privacy Rights Policy for use and disclosure of your protected health information.

Please send in all 3 pages together with a referral from your child's regular dentist.

CONFIDENTIAL FINANCIAL INFORMATION

APPLICATION WILL BE CONSIDERED INCOMPLETE WITHOUT RECENT PAY STUBS AND LAST YEAR'S INCOME TAX RETURN

(EqualityCare Recipients (Title 19) only need to fill out Dental Insurance Portion on this page and do not need to submit pay stubs and income tax return)

4. PERSONAL INCOME (INCLUDE ALL INCOME FROM ALL MEMBERS IN THE HOUSEHOLD)

(HOUSEHOLD MEMBERS INCLUDE- Parent (s), Stepparents, Legal Guardian, Parent's Significant Other, Grandparent, Sibling, Aunt/Uncle, Etc.

Member Relationship			
Occupation			
How many months of the year are you employed?			
Months/Years at Current Job			
Monthly Gross Income			
Amount in Savings			
Child Support, Alimony, or Family Benefits Received			
Social Security – SSI, SSDI, Retirement or Survivors Benefits			
Other Income: Dividends/Interest, Business Income, (i.e. Rental) Real Estate			
Unemployment/Workman's Compensation			
Other, Farm			
Per Capita			

5. DENTAL INSURANCE & BENEFITS: (Attach coverage information) If there is no Dental Insurance indicate "None"

Insured's Name, Company Name, Address	**Benefits**

FAMILY CASE SHEET

This social summary will be used to assist in determining eligibility for Dental Services provided by the Dental Health Program. All information given is kept confidential.

Patient's Name:_____DOB:_____

Address:_____

City, State, Zip:_____

ALL MEMBERS IN HOUSEHOLD – NOT INCLUDING PATIENT

Name: Last, First	Relationship to Patient	Birthdate (mm/dd/yy)	Occupation/School

I (We) apply for orthodontic care of _____by Dental Health Services. I will apply all dental insurance benefits I receive to the cost of my child's care. I understand that Dental Health Services/Severe Malocclusion Program must give prior authorization for any care for which the program is to pay.

The information you have provided will remain confidential with the Department of Health**, EXCEPT** in the following circumstances:

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I hereby authorize the release of information limited to payment information (as described above) to state agencies, insurers, group dental plans, third party administrators, health maintenance organizations or similar entities for the purpose set forth above**.**

ALL INFORMATION I HAVE PROVIDED ON THIS APPLICATION (3 pages) IS TRUE TO THE BEST OF MY KNOWLEDGE.

Signature: _____Date:_____